

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 12274

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Martha E. Butler		4 13 87		2:37A M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	Caucasian	Sept. 17, 1896	90	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md	U.S.		Somerset MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Crisfield	Alice Byrd Tawes Nursing Home	Housewife			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md	Somerset	Pc Anne	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Antioch Avenue, 21853	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Edward B. Deaton		Mary M. Townsend			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		213-16-8137		Wilmore Butler Bx 326 Rt 1 Salisbury, Md 21801	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Sepsis					1 WK
DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal stricture					Years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)					
Organic Brain Lesions L/H HSCVD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN STREET COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 4-10-87 to 4-13-87, that (1) (we) last saw the deceased on 4-10-87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
James P. Stealing MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4/15/87		OLivett	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
NAME		CITY OR TOWN COUNTY STATE		23f. REGISTRAR'S SIGNATURE	
James L. Hinman		Whitesburg Worcester Md		APR 20 1987 Julia Sanders-Randall	
ADDRESS		23f. REGISTRAR'S SIGNATURE			
Pc Anne, Md 21853					

RECEIVED
JAN 20 1964

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12275

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Van Norman Coulbourne										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4-8 1987				2b. HOUR 1987			
3. SEX Male		4. RACE BLK.		5. DATE OF BIRTH MONTH DAY YEAR 1 7 1926		6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR April 8 1987				2d. HOUR 1987			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Marion				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD.							
10. CITY OR TOWN OF DEATH Crisfield				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ed. McGready Memorial								12a. USUAL OCCUPATION (TYPE OF WORK) (FOR MOST OF WORKING LIFE) Restaurant Worker				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY Somerset				13c. CITY OR TOWN Marion				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS Tullo Corner Rd. Marion Md.			
14. FATHER'S NAME FIRST MIDDLE LAST Peter C. Coulbourne								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Brinkley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes.				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-20-4472				17. INFORMANT ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b): DUE TO, OR AS A CONSEQUENCE OF (c): Harte MI CAD X years																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE James A. Sterling				TITLE (SPECIFY) M.D. 320 W. Main Street				MEDICAL EXAMINER Crisfield, Maryland				DATE SIGNED 04-09-87							
EXAMINER'S NAME (TYPE OR PRINT) James A. Sterling, M.D.				ADDRESS 320 W. Main Street Crisfield, Maryland 21817															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Apr. 11, 1987				23c. NAME OF CEMETERY OR CREMATORY Mt. Peer Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Marion Somerset Md.							
24. FUNERAL DIRECTOR NAME Norma J. Ward				ADDRESS P.O. #119 Marion, Md.				25a. DATE REG'D. BY REGISTRAR APR 14 1987				25b. REGISTRAR'S SIGNATURE A. A. Gordon-Randall							

4/15



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

8 7 REG. NO. 1 2 2 7 0

1. DECEASED NAME (TYPE OR PRINT) Harriet Gertrude Flurer			2a. DATE OF DEATH MONTH DAY YEAR 04 29, 87		2b. HOUR 2:35AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 09 13, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD.	
10. CITY OR TOWN OF DEATH Pr. Anne	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manokin Manor Nursing home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Somerset	13c. CITY OR TOWN Pr. Anne	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Flurer Lane 21853
14. FATHER'S NAME FIRST MIDDLE LAST Henry Flurer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Frances Long			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-24-5406		17. INFORMANT ADDRESS Henry Flurer, Salisbury, Md. 21801	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Pneumonia (presumed)**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Senile Dementia-Alzheimer type**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

ASCVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Charles D. Stegman</i>	DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/29/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Stegman, M.D.		22e. ADDRESS Mt. Vernon Road, Pr. Anne, Md. 21853	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 05/02/87	23c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian	23d. LOCATION CITY OR TOWN COUNTY STATE Pr. Anne Somerset Md.
24. FUNERAL DIRECTOR NAME <i>James E. Heiman</i>		25a. DATE REC'D. BY REGISTRAR MAY 5 1987	
ADDRESS <i>R Anne, md</i>		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>	

BP _____

DATE: FEB 1968

1. *Phrynosoma*

Chlorine

00000000000000000000000000000000

2004

Female Genitalia - Abdomen: 4/10

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 12271

1. DECEASED NAME (TYPE OR PRINT) Anna A. Gibson			2a. DATE OF DEATH MONTH DAY YEAR 4-24-87		2b. HOUR 11:30 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD.	
10. CITY OR TOWN OF DEATH Crisfield		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edw. W. McCready Mem. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY - - - -	
13a. STATE Maryland		13b. COUNTY Somerset		13c. CITY OR TOWN Crisfield		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 7 E. Main St. (21817)		14. FATHER'S NAME FIRST MIDDLE LAST Rudolph G. Anklam		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Mai		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) none	
16b. SOCIAL SECURITY NO. 216-46-3008		17. INFORMANT 7 W. Main St. Lionel C. Gibson, Jr. Crisfield, Md. 21817		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 8585 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Theophylline toxicity</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/24/87</u> 19 to <u>4/24/87</u> 19, that (I) (we) (we) saw the deceased alive on <u>4/24/87</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Christjon Huddleston</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Christjon Huddleston		22e. ADDRESS 25 Broad St., Princess Anne, Md.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/27/87	
23c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield Somerset Md.		24. FUNERAL DIRECTOR NAME Bradshaw & Sons, Crisfield, Md. 21817		25a. DATE REC'D. BY REGISTRAR APR 29 1987	
25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Rudell</u>							

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IMPORTANT: If item 18 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

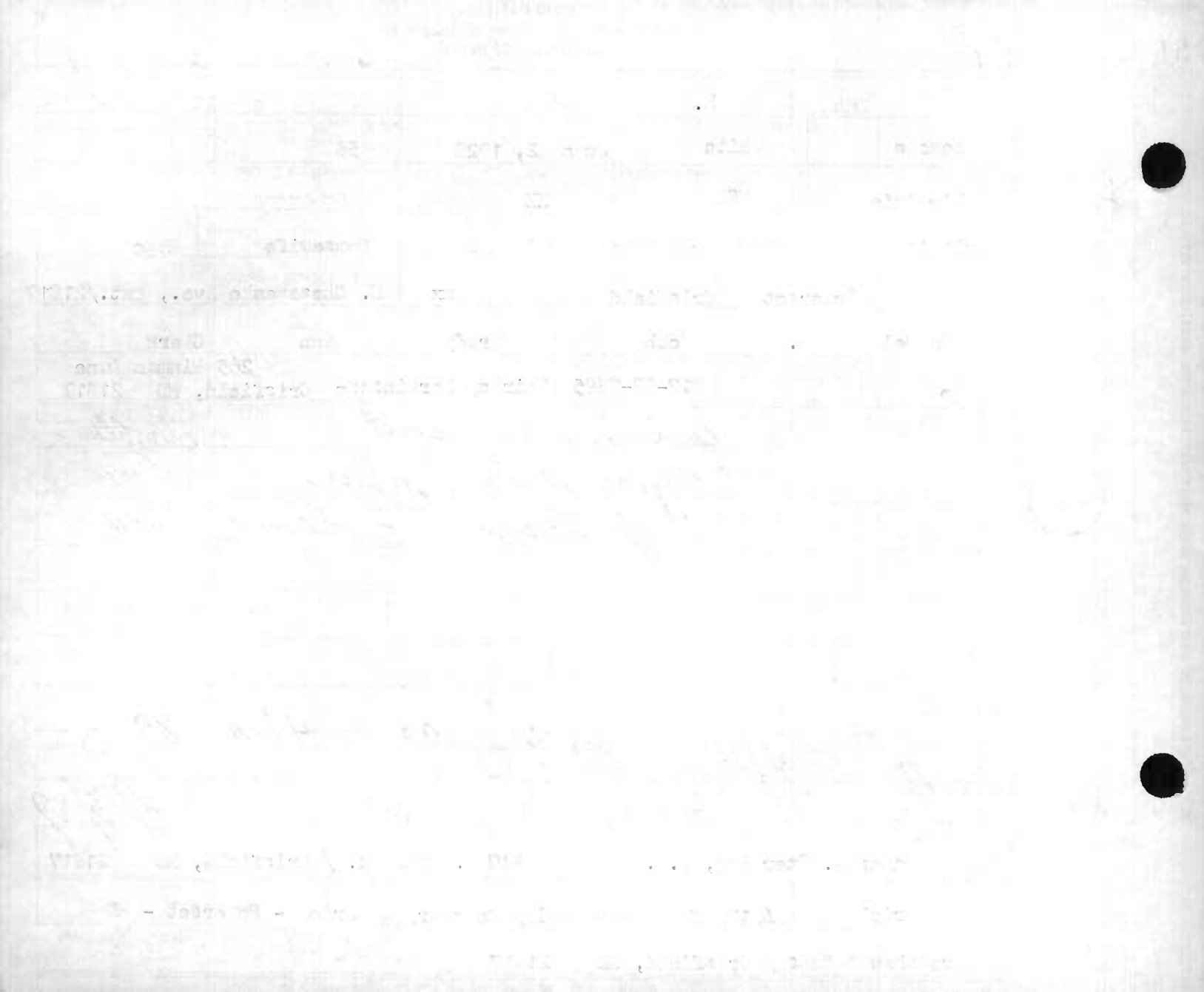
87 REG. NO. 1 2 2 7 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth R. Swift				2a. DATE OF DEATH MONTH DAY YEAR 4 15 87		2b. HOUR 2:15A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 2, 1928		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 58	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD.	
10. CITY OR TOWN OF DEATH Crisfield		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Alice Byrd Tawes Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY Somerset		13c. CITY OR TOWN Crisfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel M. Webb		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Trudy Ann Clark		16. STREET ADDRESS / ZIP CODE E. Chesapeake Ave., Ext./21817			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-07-7895		17. INFORMANT ADDRESS Shirley Parkinson- 265 Hinman Lane Crisfield, MD 21817			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Organic Brain Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cerebral Lesion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Leaves Leaves						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Leaves Leaves	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/2/87 to 4/15/89 , that (I) (we) lost 4/15/89 saw the deceased alive on 4/15/89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE James A. Sterling, M.D.				DEGREE M.D.		22c. DATE SIGNED 4/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James A. Sterling, M.D.				22e. ADDRESS 320 W. Main St. / Crisfield, MD 21817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/17/87		23c. NAME OF CEMETERY OR CREMATORY Webb Family Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marion - Somerset - MD	
24. FUNERAL DIRECTOR NAME ADDRESS Bradshaw & Sons / Crisfield, MD 21817				25a. DATE REC'D BY REG. OFF. PAR 751 REC. STRA'S SIGNATURE APR 20 1987			

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BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 12279

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST ELIZABETH A. TYLER		2a. DATE OF DEATH MONTH DAY YEAR April 18, 1987		2b. HOUR 1:30 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD.	
10. CITY OR TOWN OF DEATH Crisfield		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12 Anchor Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator	
12b. KIND OF BUSINESS OR INDUSTRY Cutlery Mfg.							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY Somerset		13c. CITY OR TOWN Crisfield		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Byrd				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie A. Evans			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-12-5759		17. INFORMANT ADDRESS J. Wm. Balderson - Crisfield, MD 21817			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary & Cardiac Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Sjogrens Syndrome PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/14/87 to 4/19/87 , that (I) (we) last saw the deceased alive on 4/19/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE Jesus Evangelista, M.D.				22c. DATE SIGNED 4/20/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jesus Evangelista, M.D.	
22e. ADDRESS Main St. - Crisfield, MD 21817				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/20/87		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield - Somerset - MD	
24. FUNERAL DIRECTOR NAME Bradshaw & Sons -				ADDRESS Crisfield, MD 21817		25a. DATE REC'D. BY REGISTRAR APR 21 1987	
				25b. REGISTRAR'S SIGNATURE Julia Balderson-Randall			

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